

**STOP**

This a revision of the popular **STOP** sleep apnea screening questionnaire. The scoring system is at the bottom.

**Do you SNORE loudly?                      Yes or No**

**Do you often feel tired, fatigued, or sleepy during the daytime?**

**Yes or No**

**Has anyone observed you stop breathing during your sleep?**

**Yes or No**

**Do you have or are you being treated for high blood pressure?**

**Yes or No**

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**SCORE:**

**If YES to 0 – 2, then low risk of [sleep apnea](#)**

**If YES to 3 – 4 of the above, then you are at intermediate risk of having sleep apnea**